Exhibit H to Complaint

U.S. ex rel. Roark, et al. v. Medical University of South Carolina, et. al.

Graduate Medical Education Financing Basics

Association of Osteopathic Directors and Medical Educators
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Graduate Medical Education Financing Basics

Topics to be covered today:

- Sources of reimbursement for Graduate Medical Education ("GME")
- The two main components of Medicare Reimbursement and how they are calculated
  - Indirect Medical Education ("IME")
  - Direct Medical Education ("DGME")
- FTE caps, Three Year rolling average, prior year IME residents to beds ratio
- Counting Residents FTEs
  - Types of time counted and types of time excluded
  - Scheduled versus actual
  - Transitional residents, initial residency period limitations
  - Impact of out rotations
- Medicare managed care reimbursement for GME
- Examples of Medicaid financing models and models uses by other payors

Sources of Reimbursement for GME

- Medicare is primary source of reimbursement for most hospitals
  - It is not intended to reimburse hospitals for the full cost of graduate medical education; only the Medicare portion of that cost
  - Medicare is typically 30-50% of hospital volume
  - Reimbursement is driven by inpatient volumes
  - The two components of Medicare reimbursement are direct and indirect medical education (DGME and IME)
  - Settlement is via the Medicare cost report
- Medicare managed care volumes are included with Medicare volumes for both IME and DGME for the cost report settlement-reimbursement is from Medicare, not the managed care plan

Where else is GME reimbursement coming from?

- Some states offer reimbursement for GME related to Medicaid patients. This can include add-ons to inpatient rates and/or lump sum monthly, quarterly or annual payments
  - Here also, most states do not intend to reimburse hospitals for more than the Medicaid share of GME cost
  - Medicaid lump sum reimbursement is often funded via the Federal Medicaid DSH program, where states are able to receive federal contributions to the cost
  - One of the provisions of the Affordable Care Act entails significant reductions to federal funding of Medicaid DSH
- More rarely, some states Blue Cross plans will provide some reimbursement for GME

Medicare Medical Education Reimbursement

Medicare is the single largest program that provides funding for GME

- Per AAMC, the Medicare program annually reimburses hospitals approximately $3 billion in DGME out of an estimated $15 billion in DGME costs
  - DGME costs are for the direct cost of training residents including residents' salaries and benefits, teaching physicians' salaries and benefits, accreditation fees, support staff costs, space costs etc.
  - From a base year cost report (1984 if the teaching program existed then), these costs were divided by the number of full time equivalent (FTE) residents to calculate the per-resident-amount
  - The per-resident-amount updated for inflation is the basis for DGME reimbursement, **not actual cost**
  - In general current residents FTEs are applied to the per-resident-amount and the Medicare share of costs is apportioned based on inpatient days
  - Hospitals receive a lump sum every two weeks and the final reimbursement is determined on the Medicare cost report
- Per AAMC, the Medicare program annually reimburses hospitals roughly $6.5 billion in IME
  - IME costs are for the incremental patient care cost related to training residents including severity of illness not reflected in DRG assignment, and inefficiencies in care associated with training residents
  - IME costs are difficult to identify, however; AAMC cites a study that indicates costs are approximately $27 billion annually
  - Reimbursement is generally based on the ratio of residents FTEs to beds, and results in a factor that is added on to Medicare DRG payment rates

Medicare Medical Education Reimbursement

- Both DGME and IME reimbursement calculations include limitations such as the following:
  - A cap on residents FTEs based on the 1986 Medicare cost report allowable FTEs or a subsequent year if there was no teaching program in 1986-the cap for IME is not necessarily the same as the cap for DGME. Cap is applied before the weighting for residents for DGME reimbursement purposes. The cap does not apply to dental or podiatric residents. Rural Hospital caps were increased by 30% subsequent to 1986.
  - Current cost report year allowable FTEs are not based solely on the current year, but a three year rolling average including the two previous cost reporting periods
  - DGME residents FTEs are weighted by a factor of 0.5 if the resident has exceeded their "initial residency period limitation", which is determined based on the minimum numbers of years it would take to complete training in the applicable residency specialty. This has the effect of reducing reimbursement for many fellows and chiefs, as well as residents that switch specialties and/or take longer than the minimum amount of time to complete training
  - The IME resident FTEs to bed ratio used to calculate the IME add-on to DRG rates is limited to the prior year resident FTEs to beds. This has the effect of forcing hospitals to wait one year to see the financial benefit of an increase in FTEs or a decrease in beds, **all other things being equal.**

Operating IME Example

Operating Indirect Medical Education:			
		Typical Source	▪Formula = (1+ (residents FTEs to average bed days available) raised to the power of .405) -1 multiplied by 1.35
FTE cap	150.50	Per MAC or audited cost report	
Redistribution/Affiliation Adjustments to cap	(25.00)	Per MAC correspondence	
Adjusted cap	125.50	Calculation	
Current year FTEs	130.00	Current year log of FTEs	▪1.35 factor had been subject to change in past years but has not changed since 2008
Current year Dental and Podiatry Residents	5.00	Current year log of FTEs	
Current year allowable FTEs	130.50	Calculation	
Prior year allowable FTEs	129.00	PY cost report and known adjustments	▪For FTEs allowed as a result of redistribution the factor changes from 1.35 to 0.66
Penultimate year FTEs	100.50	PY cost report and known adjustments	
Three year average FTEs	120.00	Calculation	
1 time adjs (FTEs closed hospitals, new residents)	3.00	Per CMS correspondence	▪Settlement is on cost report Worksheet E Part A and regulations are at 42 CFR 412.105
Three year average FTEs plus adjustments	123.00	Calculation	
Bed days available	265.00	Current year Census by nursing unit	
Residents to beds ratio	0.4642	Calculation	
Prior year residents to beds ratio	0.4562	PY cost report and known adjustments	
Lessor of current or prior year	0.4562	Calculation	
Operating IME Factor	0.2219	Calculation	
Inlier DRG payments	75,000,000	Per rate letters, PS & R, or PPS pricer	
Projected Operating IME payments	16,646,130	Calculation	
Interim Payment Factor	0.2100	Per rate letters or PS & R	
Interim Payments	15,750,000	Calculation	
Interim Lump Sum Adjustments	1,250,000	Per rate letters	
Net settlement	(353,870)	Calculation	

Medicare IME Reimbursement

Operating IME

- IME reimbursement is usually why teaching program P & Ls are in the black-difficult to identify indirect costs, so the revenue is added but costs are not
- MEDPAC recommends reducing the IME payment factor as they believe it is currently still too high (exponent was once 1.86, now 1.35)
- Note that inlier DRG payments in this example would include DRG payments associated with Medicare Managed Care patients-hospitals must bill these claims directly to Medicare to receive credit for these
- Note the cost report allows for some adjustments to FTEs after the three year average has been calculated-this is primarily for hospitals taking on residents from closed hospitals and new teaching programs
- The same is true for adjusting the prior year residents to beds ratio
- On an interim basis, payments are made as a per inpatient case percentage add-on, but reconciled to actual on the cost report

Medicare IME Reimbursement

Capital IME:

- There is also a separate payment for capital IME
- Payment is based on Operating IME FTEs divided by average daily census(PPS units only and excluding normal newborn)
- This is converted to a factor, which is applied to capital inlier DRG payments
- Interim payments are based on this factor applied to inlier capital DRG payments for each inpatient, but reconciled to actual on the cost report
- Capital IME payments are generally small, because they are added to the capital rate, which approximately $425 before being adjusted for area wages and the DRG weight for each patient
- Factor = $\{e^{.2822 \times \text{FTEs/Average daily census}}\}-1$ where e = 2.71828

DGME Example

Direct Graduate Medical Education:							
			Typical Source				
FTE Cap	160.00		Per FI or audited cost report				
Redistribution/Affiliation Adjustments to cap	(35.00)		Per CMS correspondence				
Adjusted cap	125.00		Calculation				
Current year unweighted FTEs	134.00		Current year log of FTEs				
Current year weighted primary care and OB/GYN F	82.00		Current year log of FTEs				
Current year weighted all other FTEs	48.00		Current year log of FTEs				
Current year Dental and Podiatry Residents	5.00		Current year log of FTEs				
	Primary	Other					
Current year allowable FTEs	76.49	49.78	Calculated based on ratio of cap to current year total				
Prior year allowable FTEs	76.30	50.10	PY cost report and any known adjustments				
Penultimate year FTEs	70.10	45.35	PY cost report and any known adjustments				
Three year average FTEs	146.40	95.45	Calculation				
One time adjustments (FTEs closed hospitals)	2.00	1.00	Per CMS correspondence				
Three year average FTEs plus adjustments	148.40	96.45	Calculation				
Per Resident Amount	123,100.00	119,250.00	Per FI correspondence				
Total Approved amount	29,769,703		Calculation				
Medicare Patient Days	43,000		Per YTD Census and/or PS & R				
Total Patient days	90,000		Per YTD Census				
Medicare reimbursement	14,223,303		Calculation				
Medicare Managed Care Patient Days	7,500		Per YTD Census and/or PS & R				
Medicare Managed Care Reimbursement (and redu	2,130,270		Calculation (14.13% reduction)				
Total expected reimbursement	16,353,573		Calculation				
Interim Payments	16,100,000		Per rate letters				
Net settlement	253,573		Calculation				

Medicare Direct GME Reimbursement

- Inputs are: allowable Primary Care and OB/GYN FTEs, Allowable other FTEs, per resident amount, Medicare patient days, Medicare Managed Care patient days (again claims must be billed to Medicare), total patient days
- Interim Payments are made as a biweekly lump sum adjustment
- Formula = Residents FTEs multiplied by Per Resident Amount and Medicare and Medicare HMO percentage of total patient days
- Per resident amount is hospital specific
- For FTEs allowed as a result of redistribution the per resident amount is a national average amount
- Settlement is on cost report Worksheet E-4 (formally E-3 Part IV) and regulations are at 42 CFR 413.75-413.83

Medicare Medical Education Reimbursement-FTE Caps

The opportunities to adjust or receive exceptions to the FTE caps have been and are limited:

- There have been two national redistributions of caps where CMS engineered shifts of "excess cap FTEs" to hospitals that were over the caps and/or met other criteria-most rural hospitals were exempt from "excess cap adjustments"
  - Recipient Hospitals were determined through a criteria based application process
  - Recipient hospitals do not receive the same reimbursement levels for the additional slots
  - New cost reporting requirements for hospitals to identify the newly approved actual residents
- Some Hospitals received adjustments to the cap for new programs started prior to the end of the cost reporting period on which the cap was calculated but for which the program had not yet been through a full cycle from admission of new residents to completion of training-Interventional Cardiology was a common program for this
- Hospitals that meet applicable criteria can affiliate for purposes of applying the residents cap to actual FTEs
  - Generally, same CBSA, official joint sponsors teaching program, or commonly owned
  - Must rotate residents between the providers
  - File application prior to training year(July 1), but have opportunity to true up (prior to June 30)
  - New teaching hospitals can only participate as a cap recipient

Medicare Medical Education Reimbursement-FTE Caps

Adjustments to Caps continued:

- Hospitals can receive temporary and/or permanent adjustments to the cap for taking on residents from closed programs/ hospitals
  - CMS announces slots available and hospitals can apply for permanent cap adjustments.
  - Applications assessed based on specific criteria; being the hospital that took on some or all of the residents when the hospital closed puts you first in line
- Urban hospitals can start a rural track program in which there must be minimum level of rotations to rural settings, and which allows for an exception to the cap for the urban hospital
- Rural Hospitals can start a new specialty program
- There is periodic discussion of adding more FTEs to the national totals, particularly as so many hospitals are above their caps-Current President's proposed budget includes 13,000 new resident cap slots
- Hospitals that have not had a teaching program since 1996 can start their own teaching program and establish their own cap:
  - Cap is based on fifth year of program; highest FTE count by PGY level multiplied by number of years on program, capped at accredited slots
  - Per-Resident-Amount is based on first full year of cost, divided by FTEs. Also capped based on other area teaching hospitals
  - Payments during transition are based on actual FTEs, until the hospital has trained residents through the minimum number of years for board certification

Counting FTEs for Medicare IME and DGME

- Generally, must be an accredited program:
  - Accreditation Council on Graduate Medical Education (ACGME)
  - American Osteopathic Association (AOA)
  - American Dental Association (ADA)
  - American Podiatric Medical Association (APMA)
  - Programs that lead to board certification by the American Board of Medical Specialties (ABMS)
  - Note ACGME and AOA to develop single accreditation system
- An FTE equals the amount of time needed to fill one residency slot (not necessarily 40 hours/week)
- Count no individual as more than one FTE (across all providers)
- Count vacation, sick, and leave time that does not add to the time spent in training
- One misconception-Medicare audit contractors do not compare actual FTEs by specialty to accredited FTE slots

Counting FTEs for Medicare IME and DGME

- Exclude time spent at another hospital or provider that would be able to claim the resident themselves-this does not mean you can count them if the other hospital or other provider has no approved program or chooses not to count them
- Time spent moonlighting at your hospital or another hospital is not counted for IME or DGME purposes
  - This can typically be billed as inpatient services for outpatient services, but not inpatient services
  - These are also not “residents in non approved programs” subject to Part B cost reimbursement
- Note you are counting time based on where the resident is:
  - Do not assume the resident is on site in preceptorship arrangements
  - The count should be based on actual, not scheduled rotations
  - These are important concepts for the reimbursement personnel at your hospital-failure to understand this can lead to unexpected cost report audit disallowances of FTEs
- Providers are required to report FTEs that correspond to CAP FTEs received in the latest redistribution

Counting FTEs for Medicare IME and DGME

- Generally include time spent in non hospital sites as long as the hospital is compensating the residents for their time
  - This has not always been the case; at one time this could not be counted for IME, at other times there have been complicated formulas required to show that the hospital was incurring a significant % of the cost including teaching physician cost
  - The site should be one that is primarily engaged in patient care. Residents rotating to University locations are generally not included for Medicare reimbursement purposes
- Do not count time Residents are rotating to other hospitals, regardless of who is paying for the resident
  - I have in the past seen some Medicare audit contractors allow this as long as the other hospital was not counting the time, but this is not appropriate and is increasingly rare
  - Ideally, the other hospital is compensating your hospital for the salary and fringe benefits, but this does not always happen
- There are new requirements that hospitals segregate time counted that was spent at non provider sites
- Time is reported to Medicare via the IRIS electronic record submitted with the Medicare cost report

Counting FTEs for Medicare IME Specifically

- For IME, count the time the resident spends in inpatient and outpatient areas of the hospital that are subject to PPS(exclude time spent in PPS exempt subproviders)
- Important to remember to count time based on where the resident is training, not the specialty. A common mistake I have seen is that Psychiatric residents are counted as being in the Inpatient Psychiatric unit, regardless of where the training takes place. This is important because PPS exempt inpatient psychiatric units and Rehab units have their own separate reimbursement for IME
- Count Didactic time spent as long as it is spent in the hospital
- Do not count time spent on research, unless it relates to a specific patient's care
- Both Inpatient Psychiatric Hospitals and Units and Inpatient Rehabilitation Hospitals and Units have IME provisions unique to those payment methodologies, and caps that are specific to those programs as well

Counting FTEs for Medicare DGME Specifically

- For DGME, count the time the resident spends in inpatient and outpatient areas of the hospital that are subject to PPS **and** include time spent in PPS exempt subproviders
- Count Didactic time spent as long as it is spent in the hospital **and** include time spent in non hospital sites
- Count Research time that is incurred at the hospital site. Otherwise, do not count time spent on research, unless it relates to a specific patient's care
- PGY (post graduate year) refers to the year of training the resident is currently enrolled in and is important for FTE weighting purposes
  - It is critical that the IRIS submission to Medicare reports both the residency specialty and the PGY correctly so the resident FTE is appropriately weighted at 100% or 50%
- For DGME, residents must be counted by specialty as different PRAs apply to Residents in Primary Care and OB
- Weighted Residents-certain residents FTEs are weighted by a factor of 0.5 for purposes of Medicare reimbursement-note that the residents FTEs are compared based on unweighted FTEs, and the percentage disallowance, if any, is then applied to the weighted count of FTEs

Counting FTEs for Medicare DGME Specifically

Weighted GME Residents FTEs

- Used to apply to foreign medical graduates that did not pass their equivalency exam
- Now applies to residents that continue training past the minimum number of years required for Board Certification in each specialty, not to exceed 5 years, referred to as Initial Residency Period (IRP) limitation
- IRP limits are based on the first specialty chosen by the resident, except for certain "combined programs" such as internal medicine/pediatrics
- Exceptions of up to two years for preventative medicine and geriatrics completed after other specialties

Counting FTEs for Medicare DGME Specifically

Weighted GME Residents FTEs

- In general, programs affected are:
  - Programs with prerequisites (Sometimes applies when an Osteopathic residents transfers to an ACGME program and the ACGME program does not give credit for the first year of Osteopathic training)
  - Combined programs where one or more of the specialties does not relate to primary care
  - Subspecialty programs requiring the completion in a specific specialty prior to starting the subspecialty program
  - Establishing a Transitional Year specialty accredited program is one way to help reduce IRP limitations-the IRP count does not start until the resident's second year, when a specialty is selected
  - In Osteopathic programs, a Traditional Year specialty accredited program is treated the same way an ACGME transitional year program is treated
  - In CMS final rules for 2005 and 2006, CMS indicated that residents that simultaneously(or before first year training starts) match for both a preliminary year program and a second year specialty program begin their IRP in the second year

Medicare Managed Care Reimbursement for GME

Medicare managed care payors will not reimburse hospitals for teaching, because:

- Medicare includes managed care reimbursement on the cost report for both IME (Operating only, not capital) and DGME
- Hospitals must bill Medicare directly for all Medicare managed care claims in order to receive credit for Medicare managed care-have one year after the end of the cost reporting period to do so
- PS & R report type 118 reports the claims information related to these claims; specifically the inpatient inlier DRG payments to which the IME factor is applied, and the inpatient days used to calculate the Medicare portion of DGME reimbursement
- DGME reimbursement for Medicare managed care is reduced by 14.3% to pay for the Medicare allied health Medicare managed care reimbursement
- Medicare managed care days for the PPS exempt units such as Rehab and Psych are reflected in the DGME days **if they are billed to Medicare**

Medicaid Reimbursement for GME

- Many (most?) states offer some reimbursement for the Medicaid share of GME costs
- Can be paid as an add-on to inpatient rates or lump sum periodic payments(the latter is probably more common)
- Often payments are determined in a base year and not adjusted for subsequent changes in the individual hospital teaching program(e.g. New York and Pennsylvania)
- Reimbursement is often through the Medicaid DSH program, which is scheduled for reduction beginning in Federal Fiscal Year 2016
- Some states reimburse hospitals for both IME and DGME (eg New Jersey, which also reimburses hospitals for the Charity Care portion of GME)
- State reimbursement for teaching programs is often a political football, with caps on total reimbursement changing frequently and dependent on optimizing federal funding that may be shrinking
- Individual hospitals may not receive more from Medicaid than the cost of treating Medicaid and indigent patients

Questions????

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